Canadians
living with diabetes
deserve the drugs, supplies, education, care and financial support needed to
manage their disease no matter where they live in Canada.

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The Canadian Diabetes Association and Diabète Québec thank the federal, provincial and territorial ministers of health and their staff for assisting in developing Diabetes Report 2005. The information, advice and knowledge provided have ensured that this report is a thorough analysis of the best practices in diabetes programs and services offered across Canada as of September 2005.

We also thank the members and volunteers who enriched our understanding of the reality of living with diabetes by telling their personal stories. As a result, this report also offers a unique and personal picture of the changing face of diabetes in Canada.

Research on government diabetes programs and services was conducted by Jeffery A. Johnson, Ph D, and Samantha Bowker, MSc, Alliance for Canadian Health Outcomes Research at the Institute of Health Economics. Key findings of an online survey of our members conducted by SES Research Inc. are referenced throughout this report, and the survey of costs of diabetes medications was provided by Advocacy Solutions and Brogan Inc. We thank the researchers and our writer for their work.

This project was funded by an unrestricted educational grant from GlaxoSmithKline Inc. We thank GlaxoSmithKline Inc. for its continuing support of this research.

Finally we wish to thank all participants who gave their time to the creation of Diabetes Report 2005, and extend an invitation to readers to provide comments on the data and information presented in this document.
The Canadian Diabetes Association and Diabète Québec are committed to improving standards and best practices in diabetes care, programs and services across Canada so that all Canadians living with diabetes are able to treat and manage their disease according to the best available research evidence.

In our two previous reports, Diabetes Report Card 2001 and Diabetes Progress Report 2003, we assessed federal, provincial and territorial policies and programs. Diabetes Report 2005 builds on the data collected and analysed in these reports. We see not only the serious face of diabetes across Canada, but also the significant challenges facing all jurisdictions struggling to sustain the quality of our healthcare system. We salute their efforts; however we remain convinced that the impact of diabetes with its serious complications is the greatest threat to the sustainability of Canada’s publicly funded healthcare system.

Generally, federal, provincial and territorial governments acknowledge the need to prevent type 2 diabetes in order to halt or reverse the growth in numbers of Canadians diagnosed with this chronic disease. Yet the numbers living with type 2 diabetes grows daily.

Canada has a diabetes epidemic. More than two million Canadians have diabetes today, and it is projected to be over three million by 2010. This projection is a conservative estimate in light of the tripling of the number of overweight or obese children and youth in the last 10 years and the aging of our baby boomers. First Nation, Inuit and Métis peoples as well as new Canadians from high-risk countries also face substantial growth in numbers affected.

The direct costs to all Canadians for treating diabetes in our hospitals and healthcare system are projected to increase 76 percent by 2016. The indirect economic impact of diabetes on the Canadian economy will also grow. Today the impact of diabetes on our overall economy is estimated at over $13.2 billion.

Without action, more Canadians will live with diabetes, and more will suffer the serious complications, including heart disease, stroke, kidney disease and blindness, arising from diabetes. Ultimately all Canadians pay the price for diabetes complications — for hospitalization, rehabilitation and productivity loss.

Efforts are being made to improve programs and services for Canadians with diabetes by federal, provincial and territorial governments. Intentions are good. However, if you live with diabetes, it continues to matter where you live in Canada. If we want to ensure the sustainability of our healthcare system, we must eliminate the disparities and gaps in access to diabetes medications, supplies, care, treatment and education across Canada.

An immediate step is to improve communication about existing financial assistance programs available to people with diabetes. An online survey of members of the Canadian Diabetes Association and Diabète Québec conducted in summer 2005 revealed that only 25 percent of Association and 5 percent of Diabète Québec members were aware of any federal, provincial and territorial financial assistance programs to help them manage their diabetes. Canadians who are eligible for existing government support should be made aware of how they can access these programs to help them manage their diabetes.
Secondly, the federal government must take a leadership role to ensure that all Canadians living with diabetes are able to access the medications, devices and supplies they need to manage their disease. Canadians with diabetes living in Prince Edward Island, for example, should not be at greater risk of a heart attack or stroke than someone with diabetes living in Saskatchewan. Canada’s Health Ministers acknowledged this in both the 2003 and 2004 Health Accords, when they stated “no Canadian should suffer undue financial hardship in accessing needed drug therapies. Affordable access to drugs is fundamental to equitable health outcomes for all our citizens.”

Diabetes Report 2005 reflects the urgency we believe diabetes poses for the Canadian healthcare system. The number of Canadians living with diabetes, the increasing numbers of Canadians at risk of the disease, and the direct medical costs of treating diabetes means that good intentions are no longer good enough. Attempts to reduce wait lists for hospital beds or physician visits will not succeed unless we tackle one of the critical root causes — diabetes and its complications.

It is time for all of us to get serious about diabetes in Canada. Both of our organizations have already started. We work with all governments, healthcare professionals, researchers, industry and all Canadians to raise awareness about the seriousness of diabetes, but also to say we can act to prevent diabetes from overwhelming our healthcare system!

Type 2 diabetes may be prevented or delayed, and the serious complications of diabetes may be prevented or deferred, if people with diabetes are able to manage their disease according to the best available medical advice. For Canadians living with diabetes today, it is critical that their efforts to avoid the serious diabetes related complications are supported. Improving programs and services that help Canadians with diabetes to manage appropriately, as well as directing resources to research best practices in diabetes treatment, management and education and to find a reversal or cure for this progressive disease remains critical for all Canadians concerned about the sustainability of our healthcare system.

We welcome your feedback and support. Please contact us at advocacy@diabetes.ca.

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The greatest challenge for Canadians living with diabetes remains affordability and access to diabetes medications, devices and supplies. The out-of-pocket costs for medications, devices and supplies required to manage diabetes in each province or territory varies dramatically across the country. It still matters where you live in Canada, if you have diabetes.

Cost is not the only factor restricting access for Canadians living with diabetes. Newer therapeutic interventions that are proven safe and effective by Health Canada, and available to people with diabetes in other countries, are not readily available for those with diabetes in Canada.

Across Canada there are examples of programs and services for people with diabetes that we believe should be considered best practices. Since 2003, the majority of jurisdictions have substantially enhanced or introduced new programs or services ranging from physician incentives to enhance the quality of care for people living with diabetes, to new programs to assist low-income Canadians with diabetes with the purchase of insulin and supplies, to incorporating new technology and information systems to support diabetes management within primary healthcare delivery. Access to diabetes education remains a concern, and the limited support provided by the majority of jurisdictions to this critical aspect of diabetes management needs serious attention.

Differences exist in diabetes policies and programs across Canada. Funding and staffing levels continue to vary considerably, reflecting the population and tax base in the province or territory. Six provinces have diabetes strategies with specific objectives and outcomes in place for prevention, care, education and surveillance, and most also include an Aboriginal component. Six jurisdictions are developing diabetes strategies or chronic disease strategies with a diabetes component. On a cautionary note, federal support for the Canadian Diabetes Strategy was announced by the federal government as part of the Integrated Healthy Living and Chronic Disease Strategy. The specific commitments to the five key elements of the strategy are expected to be announced before the end of 2005.

Several jurisdictions have forged strategic partnerships with the Canadian Diabetes Association to develop programs or health promotion for diabetes care and the prevention of type 2 diabetes. All jurisdictions recognize and support the Canadian Diabetes Association 2003 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada – the best available evidence-based clinical practice guidelines in the world. All jurisdictions also recognize and support the Canadian Diabetes Association Standards for Education.

Since our initial Diabetes Report Card 2001 and Diabetes Progress Report 2003, some progress has been made by most jurisdictions in the programs and services they provide for Canadians with diabetes.
Our 2005 Recommendations

1 Create and appropriately fund a national catastrophic drug plan
Some provincial governments do not have the population or tax base that provides fair and equitable access to the medications, devices and supplies that Canadians with diabetes need. The creation of a national catastrophic drug plan with a national formulary that provides the highest level of coverage currently available to eligible Canadians is the first of a number of critical steps towards addressing the current inequalities and gaps in access to appropriate diabetes medications, devices and supplies.

2 Ensure that the cost for diabetes medications and supplies, as well as the costs associated with diabetes-related complications, are not a barrier or a burden to an individual managing her or his diabetes.
All jurisdictions have a responsibility to ensure the funding, programs and services they deliver help reduce the very real financial burden confronting Canadians with diabetes and their families.

3 Increase awareness of existing government programs and services for Canadians living with diabetes
All federal, provincial and territorial governments should better inform Canadians with diabetes about the financial assistance and support programs and services currently available, and facilitate more efficient and effective access for Canadians with diabetes and their healthcare providers.

4 Implement the Canadian Diabetes Association 2003 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada
While all jurisdictions acknowledge the Association’s 2003 Clinical Practice Guidelines as the best available research evidence for preventing and managing diabetes and have incorporated aspects of the guidelines in programs and services, the guidelines should be fully implemented.

5 Accelerate and enhance implementation of the Canadian Diabetes Strategy and the Aboriginal Diabetes Initiative (ADI)
Although federal funding for the Canadian Diabetes Strategy was announced, specific commitments to the five key elements of the strategy remain unknown. The federal government continues to support the National Diabetes Surveillance System (NDSS), and preparations for the renewal of the Canadian Diabetes Strategy as part of the Integrated Strategy on Healthy Living and Chronic Disease are underway. While federal funding for research and the NDSS supports our ability to make appropriate investments in public policy measures, community-based projects, programs and services are critical to slowing, stopping or reversing the growth of diabetes. Federal announcements are expected before the end of 2005 on the specifics of how the enhanced Canadian Diabetes Strategy will be implemented over the next five years. In particular, in recognition of the diabetes epidemic in Aboriginal communities, the ADI must be a high priority for implementation.
Our goal in Diabetes Report Card 2001 and Diabetes Progress Report 2003 was to identify the gaps and work towards fair standards and best practices in diabetes care and access across Canada. By 2011, we will have a comprehensive database of all government efforts to support Canadians with diabetes over the decade. Until then, we recognize the limitations of our analysis, and rely on the advice of independent, academic experts on what constitutes best practices in jurisdictions across Canada today.

In Diabetes Report 2005, we assessed diabetes policies or strategies, standards and guidelines, diabetes surveillance, as well as financial support and access to diabetes medications, devices and supplies. Diabetes Report 2005 also acknowledges that primary prevention programs and healthy living initiatives are increasingly used to address common risk factors for chronic diseases, including diabetes.

However, primary prevention and initiatives to encourage healthy eating and physical activity do little to help those living with diabetes in Canada today. Governments have a responsibility to help those diagnosed to manage their diabetes effectively. The recent Diabetes in Canada Evaluation (DICE) results suggest that government needs to be more proactive by providing physicians with tools to help them manage diabetes. While the scientific evidence strongly recommends achieving blood glucose targets of seven percent or lower, nearly half of Canadians with type 2 diabetes in the DICE study were not at target. Among people who had diabetes for 15 years or more, 62 percent did not have their blood glucose under control. Sixty-three percent of those in the study had high blood pressure, 59 percent had high cholesterol, 38 percent were diagnosed with microvascular complications such as cataracts, foot disease or neuropathy, and 28 percent were diagnosed with macrovascular complications such as heart attack, stroke or stable angina.

Family physicians face increasing demands to manage type 2 diabetes in their daily practice, and although aware of the Canadian Diabetes Association 2003 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada, they need help from governments to implement the more intensive treatment strategies recommended for this complex disease with its serious complications.

A comprehensive approach is the only way to address the challenges. The Canadian Diabetes Association 2003 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada is the best-available scientific and evidence-based set of guidelines on the appropriate management strategies available for physicians and healthcare professionals. Today, the best-available scientific evidence clearly shows the benefits of intensive management and multiple interventions to control blood glucose levels in the prevention of the serious complications in all types of diabetes.

Diabetes Report 2005 shows that the face of diabetes programs and services across Canada is changing. More than two million Canadians have diabetes today, and more than three million will be diagnosed by 2010. By 2011, more than 50 percent of Canadians will be age 40 or over, and therefore considered at risk of type 2 diabetes. In July 2005, Statistics Canada reported that two out of every three Canadian adults and nearly one out of every three children between 12 and 17 are overweight or obese. Unhealthy weight and lack of physical activity increase the risk of developing type 2 diabetes. Jurisdictions are increasingly directing their efforts at the prevention of type 2 diabetes in an effort to slow the increasing numbers of those being diagnosed.
Healthcare renewal and diabetes

Healthcare renewal and primary healthcare reform were key objectives coming out of both the 2003 and 2004 First Ministers’ Accords on Health Care. More than $41 billion was committed to a 10-year plan in 2004 to renew Canada’s healthcare system. Primary care reform, the introduction of multi-disciplinary teams to better meet patient needs, increased home care support, health promotion, as well as the development of a national pharmaceutical strategy were announced by the federal, provincial and territorial ministers.

The healthcare renewal agenda is critical in the prevention and management of all types of diabetes and its associated complications, including heart disease, kidney disease and adult blindness. In January 2005, the Health Council of Canada urged that federal, provincial and territorial governments move forward with these reforms on an accelerated basis. We echo the Health Council of Canada’s recommendation.

While we support the healthcare renewal agenda, the lack of awareness by decision-makers about the impact of type 2 diabetes, as well as the growth in the number of people affected by the complications from diabetes, is a concern. The reorganization of primary care delivery at the provincial or regional health level needs to ensure that healthcare professionals are able to manage diabetes and its complex complications effectively with their patients. The move towards healthcare teams in some jurisdictions is a step in the right direction in our opinion. Increased home care support can potentially help the growing number of seniors with diabetes or those Canadians who struggle with serious diabetes-related complications.

Healthcare teams are also well positioned to encourage healthy eating, physical activity and smoking cessation that are critical to slowing the growth rate of both type 2 diabetes and the complications of diabetes.

If decision-makers do not address diabetes within the healthcare renewal agenda, diabetes and its related complications will continue to strain the resources and capacity of our hospitals, doctors and healthcare professionals, and add to the waitlists for physicians, hospital beds, surgeries and home care services. At a time when 50 percent of people with diabetes have serious complications that require more visits to doctors, more stays in hospitals, and more money spent on medications, tackling diabetes must be a part of healthcare renewal in Canada.

National Pharmaceutical Strategy (NPS)

One component of the healthcare renewal agenda that impacts directly on all Canadians living with diabetes is the NPS that is designed to identify how government can ensure that Canadians are protected from undue financial hardship for prescribed medications and supplies, but also able to get safe, effective and affordable medications when they need them.

An early component of the NPS is the Common Drug Review (CDR) which was designed to streamline formulary decisions for drug plan managers by reviewing the therapeutic value and cost-effectiveness of new medications and recommending whether to list on drug benefit plan formularies. In March 2004, a pilot project called COMPUS — the Canadian Optimal Medication Prescribing and Utilization Service — was also launched. COMPUS started with three pilot projects designed to
collect and evaluate the best practices in drug prescribing and use, as well as disseminate and encourage implementation of best practices for proton pump inhibitors, diabetes management and anti-hypertensive medications. Our Association is closely monitoring the activities of both CDR and COMPUS.

The Canadian Diabetes Association believes that it is time for Canada’s healthcare decision-makers to get serious about diabetes. We believe the healthcare renewal efforts by all jurisdictions, the CDR and COMPUS, as well as the NPS will ultimately fail unless Canadians with diabetes are included in the critical discussions determining their future direction.
The following section highlights what each jurisdiction reported as examples of best practices in diabetes strategies, programs and services across Canada.

A summary of the federal, provincial and territorial responses to our survey prepared by our researchers, as well as the complete research report is available online as Appendix A at www.diabetes.ca. The summary of research organizes the findings in four areas: diabetes policy or strategy; standards and guidelines; primary prevention programs; and diabetes surveillance.

All jurisdictions were asked to identify what they considered to be their best practice in each of the four areas. The best practices were then aligned with our six original recommendations in Diabetes Report Card 2001 that will remain the framework for reporting our findings until 2011.

We continue to collect all the data and information provided by the federal, provincial and territorial governments in our database of diabetes programs and services that we began in 2001 and continued in Diabetes Progress Report 2003. Information will be collected regularly until 2011, when we will be able to provide a comprehensive analysis of what changes have occurred over the ten years in the provision of programs, services and supports in each jurisdiction.

**2001 Report Card Recommendation 1**
Commit to the development, funding and implementation of a long-term national diabetes strategy, under the leadership of the government of Canada, which addresses prevention, care and treatment, education, research and surveillance.

Although federal funding for the Canadian Diabetes Strategy was announced as part of the Integrated Strategy on Healthy Living and Chronic Disease, the specific details of the five key elements of the strategy are still to be announced.

While federal funding for research and the NDSS supports our ability to make appropriate investments in public policy measures, community-based projects, programs and services are critical to slowing, stopping or reversing the growth of diabetes. Those Canadians or communities at high risk of type 2 diabetes must be targeted. In particular, in recognition of the diabetes epidemic in Aboriginal communities, the ADI must be a high priority for implementation.

- All provinces and territories continue to participate in the NDSS, and most jurisdictions have used NDSS data to issue reports on diabetes.
- British Columbia issued A Snapshot of Diabetes Care in British Columbia, 2003-04, which includes information on prevalence and incidence rates of diabetes; co-morbidities and complications; and utilization of health care services for people with diabetes.
- Alberta and Quebec reported on diabetes prevalence, incidence and rates for co-morbidities and complications in their jurisdictions.
• Saskatchewan issued the Saskatchewan Diabetes Profile 1996-97 to 2000-01 in 2004-05 with prevalence trends, co-morbidities and mortality at the provincial and health region level.

• The Manitoba Diabetes Care Project used provincial administrative data sets to evaluate the impact of the Manitoba Diabetes Care Recommendations on the practice patterns of primary care physicians.

• The Institute for Clinical Evaluative Sciences (ICES) Ontario Diabetes Atlas 2003 was released in 2004.

• Diabetes in Nova Scotia: A ten year perspective in 2003 reported on Nova Scotia’s rates of hospitalization and related lengths of stay in hospitals for those with diabetes, and a significant increase in the utilization of Diabetes Centres for initial and on-going education. In September 2004, the first NDSS report - Diabetes in Nova Scotia, 2000/01: Prevalence, Incidence, Mortality, Morbidity, and Utilization, was released.

2001 Report Card Recommendation 2
Develop or enhance formal provincial or territorial diabetes policy strategies with dedicated diabetes staff to ensure that diabetes is a key health priority.


Alberta and Saskatchewan identified a 10-year time (2003-13), with ongoing funding and identified targets and measurable outcomes to ensure sustainability. British Columbia, Manitoba, Ontario and Nova Scotia provide ongoing funding, but no explicit time limitation. New Brunswick includes diabetes in its Chronic Disease Management Strategy. Newfoundland and Labrador, Prince Edward Island, Quebec, Nunavut, Yukon and Northwest Territories have strategies for diabetes or chronic disease management in development and advise they expect completion shortly.

Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia and Prince Edward Island have dedicated staff positions to coordinate diabetes policy and programs. Specific enhancements to formal diabetes policy strategies includes the following:

• British Columbia, Alberta, Saskatchewan and Manitoba support a multi-year collaboration led by the Western Health Information Collaborative (WHIC) that develops and uses information systems to support diabetes management within the delivery of primary health care as part of its Chronic Disease Management Infrastructure.

• Manitoba introduced a Regional Diabetes Program that includes Risk Factor and Complication Assessment and a Multi-level Diabetes Education Program.

• Quebec, working with Diabète Québec, produced Meal Planning for People with Diabetes to be distributed by dietitians and a brochure entitled A Glance at Meal Planning for broader public distribution. Quebec also established subcommittees to examine and make recommendations involving the built environment, clinical practices, 0-5-30 (zero tobacco, 5 portions of fruits and vegetables and 30 minutes of physical activity) and the socio-cultural environment to prevent chronic disease.

• Ontario established a Diabetes Task Force in 2003 to review existing programs and services, and to advise on evidence-based priority actions to address the prevention of type 2 diabetes, as well as the management and care of diabetes to minimize complications. The province developed an Aboriginal Diabetes Strategy and implementation plan.
• The Diabetes Care Program of Nova Scotia (DCPNS) with stated objectives and outcomes related to diabetes prevention, care, education, and surveillance also supports applied research to encourage innovation in program delivery within an integrated strategy of chronic disease management. The DCPNS also ensures the needs of special populations or issues are addressed by subcommittees or working groups, for example, the Pregnancy and Diabetes Committee, the Children and Adolescents with Diabetes Committee and the Long Term Care Committee.

• New Brunswick includes diabetes in its Chronic Disease Management Strategy and Manitoba introduced a Chronic Disease Prevention initiative. Newfoundland and Labrador, Prince Edward Island, Quebec, Nunavut, Yukon and Northwest Territories report that strategies for diabetes or chronic disease management are in development.

2001 Report Card Recommendation 3
Retain responsibility to set and monitor standards and guidelines when regional health entities are charged with delivery of diabetes-related programs, ensuring appropriate resources and support to adhere to such standards and guidelines.

All provincial and territorial governments demonstrated recognition and support of the Canadian Diabetes Association 2003 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada and the Standards for Diabetes Education in Canada (2000) that was revised and an updated edition released in October 2005.

Regional health authorities are increasingly being asked to report on adherence to diabetes standards and guidelines through accountability or other reporting mechanisms to most provincial or territorial governments.

• Nova Scotia publicly endorsed the 2003 Clinical Practice Guidelines in December 2003 and worked with district health authorities to educate and inform physicians in four health districts, as well as the staff at the 39 Diabetes Centres on their implementation. All DCPNS provider and patient resources were reviewed and revised to reflect the 2003 Guidelines.

• Ontario’s 2005 agreement with the Ontario Medical Association provides compensation to physicians for the additional time required to care for their patients with diabetes, as well as a dedicated payment for those over 65, who are also at high risk for type 2 diabetes. Provincialy funded diabetes programs require support of the 2003 Clinical Practice Guidelines.

• One hundred and eight of Quebec’s Diabetes Centres offer diabetes education without requiring a reference from a physician, and also offer a follow-up to people who have participated. Nine of Quebec’s regions have added new diabetes education services in the last five years.

• Manitoba supports the 2003 Clinical Practice Guidelines in the enhanced Manitoba Diabetes Care Recommendations, a practical translation of the guidelines. Copies are distributed to primary care physicians, diabetes educators, health professionals and providers to support quality diabetes care. The Diabetes Education Network workshop is another example of evidence-based continuing education for health providers and professionals in Manitoba.

• Saskatchewan distributed copies of the 2003 Clinical Practice Guidelines to each regional health authority and encouraged their inclusion in its provincial diabetes plan. It also supported a diabetes symposium on the Implications of the 2003 Clinical Practice Guidelines for Health Practitioners in September 2005.

• Alberta disseminated the 2003 Clinical Practice Guidelines through its Diabetes Patient Care Flow Sheet for health professionals, as well as in the Living Well with Diabetes Resource Calendar.

• British Columbia used the 2003 Clinical Practice Guidelines to develop and update the BC Diabetes Care Guidelines in 2004. It reports publicly on the extent to which diabetes care delivered in BC is consistent with the BC Guidelines, and includes performance targets for diabetes care in health authorities service plans. General practitioners are eligible for a bonus
payment for each patient with diabetes provided with care according to the BC Diabetes Care Guidelines.

- Newfoundland and Labrador acknowledged the 2003 Guidelines and promoted their use in the accountability reporting mechanisms used by regional health authorities and their clinical quality improvement teams.

- Prince Edward Island has a Clinical Resource Team that promotes the 2003 Clinical Practice Guidelines; disseminates the 2003 Guidelines to healthcare providers; promotes the use of a Diabetes Patient Care Flow sheet in primary health centres; and, tracks waiting lists for diabetes education.

### 2001 Report Card Recommendation 4

Commit to a strategy such that the cost to the individual for diabetes medication and supplies, as well as the costs associated with diabetes-related complications are not a barrier or a burden to managing the disease.

The federal Non-Insured Health Benefits (NIHB) program provides registered First Nations people and Inuit access to health-related goods and services (medications, dental care, vision care, medical supplies and equipment, medical transportation, short-term crisis intervention, and mental health counselling) that are not insured by provinces and territories or other private insurance plans. Canadians with diabetes who are eligible for NIHB have the best access to diabetes medications, supplies and devices in Canada.

Those who are employed may have access through a private drug plan provided through their employment – or through an immediate family member’s employment. For the most part, Canadians with diabetes who are employed in contract, part-time or minimum wage positions, or who are self-employed have to pay out of their own pocket for their diabetes medications, devices and supplies.

Provincial or territorial drug plans provide Canadians with diabetes who are over the age of 65 or on social assistance access to diabetes medications, devices and supplies listed on provincial formularies. British Columbia, Saskatchewan, Manitoba, Quebec, Nunavut, Northwest Territories and Yukon provide support for Canadians through income-related deductibles and co-payment programs. Ontario and Alberta provide limited financial support through financial assistance programs. Nova Scotia and New Brunswick recently announced programs to assist people with diabetes on low income.

- Nova Scotia announced $2.5 million in 2005 to assist low-income, uninsured Nova Scotians under the age of 65 to purchase insulin, oral medications, test strips, syringes, and lancets. The deductible will be based on income and family size.

- New Brunswick announced $370,000 annually to assist 280 low-income people with diabetes to purchase insulin and supplies.

- Ontario’s Monitoring for Health program continues to reimburse eligible insulin dependent people for their blood glucose testing strips (up to 65% of the annual cost), lancets (up to $500 a year), and a blood glucose meter (up to 65% or $75 – whichever is less) every five years.

- In September 2003, the Alberta Monitoring for Health program began providing up to $550 per year for those with insulin dependent diabetes, and up to $250 each year for those managing their diabetes with oral medications. Those managing their diabetes through diet are eligible for up to $100 a year in financial assistance.

- Canadians with diabetes continue to carry a heavy financial burden in managing the disease to avoid serious complications. Detailed charts showing financial coverage and access provisions for diabetes medications and supplies are available at [www.diabetes.ca](http://www.diabetes.ca). Go to the “Financial Coverage Charts for Diabetes Supplies and Medication” link.
2001 Report Card Recommendation 5

Establish an effective formulary system that is mindful of products providing the best outcomes based on sound medical evidence and which lists new products with proven efficacy in a timely fashion.

A significant challenge for many Canadians living with diabetes is access to newer therapeutic treatments that are safe and effective with proven positive health outcomes when appropriately prescribed. Currently the medications formulary process has several steps. Once Health Canada has approved the safety and effectiveness of diabetes medications, devices and supplies, the Patented Medicine Prices Review Board (PMPRB) approves a sale price. Then the manufacturer can sell the medication in Canada at that price. For example, Health Canada approved new therapeutic classes of medications for sale in Canada (e.g. thiazolidinediones) in the last five — and in some cases 10 — years that jurisdictions have not listed on provincial or territorial formularies. As a result, only Canadians with diabetes who have either the personal financial resources or a private health plan can afford to purchase these newer diabetes medications if prescribed by their physician. Those without the financial resources or private health plan are unable to personally afford the cost of the medications prescribed by their physician as being optimal for the management of their diabetes.

We believed the promise that the CDR would be a faster and improved process that would increase access to the newer diabetes medications for Canadians living with diabetes. CDR reviews all diabetes medications, for cost-effectiveness and therapeutic value, and then recommends to the provinces whether to list on their formularies. Please note that Quebec is the only province not participating in the CDR.

Since the CDR was launched in September 2003, only one application for a new diabetes medication — insulin glargine — has been considered under the new process. In June 2005 before CDR had finished its review of insulin glargine, Quebec listed this newest diabetes therapeutic class on their provincial formulary with restricted access. In September 2005, the CDR recommended that insulin glargine not be considered for listing on participating formularies.

Since December 2003, Newfoundland and Labrador, Prince Edward Island, Quebec, Ontario, Manitoba, Saskatchewan, Alberta, British Columbia and the NIHB improved their formulary listings by adding a new diabetes medication to the formulary, or by moving a diabetes medication from “restricted” to “listed” status, making it easier to obtain.

2001 Report Card Recommendation 6

Ensure that people with diabetes have timely, affordable and ongoing access to diabetes education and comprehensive treatment services provided by qualified professionals, including a Diabetes Health Care Team and other specialists.

Jurisdictions increasingly recognize the critical importance of timely diabetes education for people affected by diabetes, and the need to support continuing education for diabetes educators. Two trends in particular – the adoption of tele-health networks in the north and the focus on multi-level diabetes education for more integrated and multi-disciplinary diabetes health teams – may also have a positive effect over the long-term in mitigating the rates of diabetes-related complications across the country by enhancing access to diabetes education.

- **Manitoba’s Risk Factor and Complication Assessment** training support includes a train-the-trainer program and tool kit for diabetes healthcare teams. The province supports the Diabetes Education Network (DEN) workshop, a continuing education and networking opportunity for all levels of diabetes educators.

- **Nova Scotia’s DCPNS** supports Diabetes Centres with newsletters, a web site, provincial and regional workshops and other continuing education opportunities. By providing standardized documentation and data collection tools, as well as developing specific guidelines, the DCPNS Registry is able to track referral trends by referral population, diabetes type and treatment across all Diabetes Centres since 1992. The onsite Registry is currently used in 16 diabetes education centres, and allows the collection of additional process and outcomes data, as well as its review and interpretation to determine the effectiveness of diabetes interventions. The DCPNS also developed triage criteria for initial and follow-up visits to education centres, and formed a Best Practice Committee to recommend approaches for timely, accessible and quality care.

- **Nunavut’s Ikajuruti Inungnik Ungasiktumi Telehealth Network** (“a tool to help those who are far away”) provides continuing diabetes education to health professionals, as well as two-way video links to reach physicians and specialists in Alberta and Saskatchewan for medical advice.

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**New Recommendation**

Ensure that all Canadians are aware of the modifiable risk factors for type 2 diabetes through health promotion and primary prevention programs aimed at encouraging healthy weight and physical activity.

All jurisdictions acknowledge the need to prevent and reduce the common risk factors – unhealthy weight, physical inactivity, smoking – associated with diabetes and other chronic diseases. All jurisdictions have introduced primary prevention programs to encourage healthy eating and physical activity as part of chronic disease prevention initiatives or strategies. An integrated chronic disease prevention focus will increasingly encourage Canadians to understand how they may help prevent the onset of type 2 diabetes.

- **Manitoba appointed a Minister of Healthy Living** in November 2003 to create conditions and support behaviours that promote healthier choices to help reduce the risk of type 2 diabetes.

- **Alberta committed funding** for innovative primary prevention programs that address modifiable risk factors associated with chronic diseases, and specifically supports a province-wide diabetes prevention education initiative *Keep Your Body in Check*, the Alberta Healthy Communities Project and Aboriginal health diabetes projects.

- **Ontario appointed a Minister of Health Promotion** in June 2005 to promote healthy eating and physical activity. Ontario also announced *Active 2010: Ontario’s Physical Activity Strategy* that intends to increase by 55 percent the level of physical activity amongst Ontarians.

- **Quebec introduced a media campaign** to raise awareness that the portion of fruits and vegetables to be eaten daily is five, and to increase physical activity to 30 minutes a day. A series of television programs last winter called *Defi*
Sante 5/30, showed people taking the challenge to increase their fruit and vegetable intake and to be more physically active.

• BC supports prevention activities through ActNow BC by facilitating multi-sectoral prevention and health promotion to take integrated action to reduce risk factors for chronic disease. Specifically, ActNow BC promotes physical activity, healthy eating, living tobacco-free and making healthy choices during pregnancy. Initiatives target individuals, families, schools, work sites and the community.

• Manitoba’s Chronic Disease Prevention Initiative (CDPI) provides a community-led, evidence-based approach to primary prevention of the major preventable chronic diseases in Manitoba (diabetes, cardiovascular disease, cancer, lung and renal diseases). Structures and processes, including training and resources, will enable informed community action and demonstrate effective primary prevention outcomes.

• Nova Scotia’s Office of Health Promotion continues to implement the Nova Scotia Chronic Disease Prevention Strategy by promoting action in healthy eating, physical activity, tobacco control, healthy sexuality, injury prevention and addictions. The DCPNS, the Department of Health and other partners publicly launched a diabetes prevention initiative – “Can you catch diabetes? No, but it could catch you!” – aimed at individuals and families at risk for developing type 2 diabetes. The informational materials encouraged healthy eating, physical activity and weight management.

• Prince Edward Island introduced standardized “At Risk” education sessions for people diagnosed with pre-diabetes to help prevent or delay the onset of type 2 diabetes. Other innovations include a Healthy Living Strategy focused on major chronic disease risk factors, programs to encourage increased levels of physical activity, as well as reducing the cost barriers to children participating in physical activity.

• Nunavut launched primary prevention programs for Inuit and socially disadvantaged groups. A school-based “Drop the Pop” campaign designed to encourage healthy eating amongst children and youth is an example of its innovation.

• Northwest Territories held the Get Active NT Community Challenge in 2005 to encourage residents to be more physically active. From April to July 2005, residents competed for $5,000 worth of physical activity equipment to be won by four communities with the most activity per capita depending on population. Over 6,500 people logged in nearly 102,000 hours of fun physical activity.

• Saskatchewan appointed a Minister for Healthy Living Services in October 2005 to support health promotion and active living.

• The federal government created the Public Health Agency of Canada in 2004 to support integrated chronic disease strategies and healthy environments and behaviours amongst Canadians. The Canadian Diabetes Strategy now sits under the umbrella of an Integrated Healthy Living and Chronic Disease Strategy.
The best available scientific evidence embodied in the Canadian Diabetes Association 2003 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada calls for an aggressive approach to prevent, screen, diagnose and manage diabetes. All Canadians – patients, healthcare providers and governments – need to recognize the seriousness of diabetes and take action to prevent diabetes, complications, save lives and improve quality of life.

Physicians are encouraged to prevent diabetes sooner, diagnose earlier and manage diabetes more aggressively to avoid or delay complications. Healthcare professionals are asked to get their patients with diabetes to the A1C target of 7 percent or lower as soon as possible. The best available research strongly indicates that A1C levels of lower than 7 percent significantly prevents the onset of serious complications, including heart attack, stroke, blindness, amputation or kidney disease. Primary care physicians (who care for the majority of Canadians living with diabetes) need to incorporate the 2003 Clinical Practice Guidelines into their everyday practice.

To do this, physicians and patients with diabetes need access to the complete toolkit of recommended treatments. The 2003 Clinical Practice Guidelines recommend more intensified therapy with anti-diabetic agents, combination therapy involving the use of more than one medication prescribed earlier in the treatment, as well as any additional medications required to control blood pressure and lipid (blood fat) levels.

Managing diabetes requires access to medications, supplies and devices. All Canadians with diabetes require access to safe and effective medications approved by Health Canada. Once approved by Health Canada and the PMPRB for sale in Canada, anyone can purchase the medication, supply or device if they have the money.

In general, provincial or territorial drug plans provide coverage for seniors and Canadians on social assistance. War veterans, military personnel, the Royal Canadian Mounted Police (RCMP) and Aboriginal Canadians are covered under federal drug plans. Alberta, Ontario, Nova Scotia and New Brunswick provide limited financial assistance through specific programs for people with low incomes living with diabetes.

The “formulary” is a listing of all medications and medical supplies covered by a federal, provincial or territorial drug plan. A “formulary” will include a product as: full benefit and available to all who are eligible; restricted and therefore available under special circumstances; or not listed or unavailable even to eligible recipients.

While the majority of older diabetes medications (metformin and sulfonylureas, for example) are unrestricted listings on formularies, newer diabetes medications approved as safe and effective by Health Canada, are for the most part restricted or not listed by provincial formularies. The result is a two-tier system whereby Canadians with diabetes with either a private drug plan or the personal financial resources, are able to purchase the newer therapeutic treatments prescribed by their physicians. Yet those Canadians with diabetes who have limited incomes and reliant on government formularies are denied access to the newer life-sustaining medications, devices or supplies.

The chart that follows shows the federal, provincial and territorial listings for diabetes medications.
Formulary Listings for Diabetes Medication in Canada

November 2005

<table>
<thead>
<tr>
<th>Brand Name (Drug Name)</th>
<th>Class</th>
<th>BC</th>
<th>AB</th>
<th>SK</th>
<th>MB</th>
<th>ON</th>
<th>QC</th>
<th>NB</th>
<th>NS</th>
<th>PE</th>
<th>NL</th>
<th>NIHB** YT/NT/NU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actos (pioglitazone HCL)</td>
<td>Thiazolidinedione</td>
<td>R</td>
<td>L</td>
<td>R</td>
<td>R</td>
<td>NL</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>NL</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>Amaryl (glibenpiride)</td>
<td>Sulfonylurea</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>R</td>
<td>NL</td>
<td>R</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
</tr>
<tr>
<td>Avandamet (rosiglitazone maleate and metformin HCL)</td>
<td>Thiazolidinedione</td>
<td>NL</td>
<td>NL</td>
<td>R</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
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</tr>
<tr>
<td>Avandia (rosiglitazone maleate)</td>
<td>Thiazolidinedione</td>
<td>R</td>
<td>L</td>
<td>R</td>
<td>R</td>
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<td>R</td>
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<td>NL</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>Chlorpropamide</td>
<td>Sulfonylurea</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>DL</td>
<td>L</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>Diamicron MR (gliclazide)</td>
<td>Sulfonylurea</td>
<td>R</td>
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<td>NL</td>
<td>L</td>
<td>NL</td>
<td>R</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
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</tr>
<tr>
<td>Glucagon</td>
<td></td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>NL</td>
<td>R</td>
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<tr>
<td>GlucoNorm (repaglinide)</td>
<td>Meglitinide</td>
<td>NL</td>
<td>L</td>
<td>R</td>
<td>R</td>
<td>NL</td>
<td>R</td>
<td>R</td>
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<td>NL</td>
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</tr>
<tr>
<td>Glyburide</td>
<td>Sulfonylurea</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
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<td>L</td>
</tr>
<tr>
<td>Humalog (Insulin lispro)</td>
<td></td>
<td>R</td>
<td>L</td>
<td>R</td>
<td>L</td>
<td>R</td>
<td>L</td>
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<tr>
<td>Insulin(s), regular</td>
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<td>L</td>
<td>L</td>
<td>L</td>
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<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>Metformin HCL</td>
<td>Biguanide</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
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<tr>
<td>Novo Rapid (Insulin aspart)</td>
<td></td>
<td>R</td>
<td>L</td>
<td>R</td>
<td>L</td>
<td>R</td>
<td>L</td>
<td>R</td>
<td>R</td>
<td>L</td>
<td>R</td>
<td>L</td>
</tr>
<tr>
<td>Prandase (acarbose)</td>
<td>Alpha glucosidase inhibitor</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>R</td>
<td>L</td>
<td>R</td>
<td>L</td>
<td>NL</td>
<td>R</td>
<td>L</td>
</tr>
<tr>
<td>Starlix (nateglinide)</td>
<td>Meglitinide</td>
<td>NL</td>
<td>NL</td>
<td>R</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>L</td>
</tr>
<tr>
<td>Tolbutamide</td>
<td>Sulfonylurea</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>Lantus</td>
<td>Glargine</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>L</td>
<td>L</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
<td>NL</td>
</tr>
</tbody>
</table>

(L) Listed: listed on the provincial formulary as a full benefit; available to recipients who meet eligibility requirements under the public drug plan.
(R) Restricted: listed on the provincial formulary, but only available under special circumstances.
(NL) Not Listed: not listed on the provincial formulary, and therefore not available through the public drug plan, even for eligible recipients.
(DL) De-listed: medication which has been removed from a formulary.

*NOTE 1: Chlorpropamide / tolbutamide: These diabetes drugs are known as “1st generation” drugs and are rarely prescribed. They are still listed on most formularies, but some provinces have de-listed them because there are better alternatives available.

*NOTE 2: Most residents of the three Territories receive coverage for their diabetes medication under the Non-Insured Health Benefits plan (NIHB), available to registered Indians, specified Innu or Inuk peoples, or infants under one year of age whose parent is an eligible recipient. For those not eligible for NIHB, Northwest Territories follows the Saskatchewan formulary. Nunavut’s “Extended Health Benefits Plan” follows the NIHB formulary, and Yukon follows the British Columbia formulary.
A Canadian living with diabetes is likely to have a lower income and medical costs two to five times higher than a Canadian without diabetes. Statistics Canada reports that Canadians over age 35 and living with diabetes are more likely than those without diabetes to have lower levels of income. For Canadians without an employee benefit plan or private drug insurance, the financial costs of managing their diabetes can be severe.

Blood glucose test strips in particular highlight the disparities in provincial and territorial access to diabetes supplies and devices. Each test strip costs approximately $1. For Canadians with type 1 diabetes or for those with insulin-dependent type 2 diabetes, the 2003 Clinical Practice Guidelines recommend testing at least three times a day, every day. Canadians with type 2 diabetes on oral medications or managing through diet and exercise are recommended to test at least once a day. Over one year, test strips cost approximately $1,095 for someone with insulin-dependent diabetes.

Some federal, provincial and territorial drug plans cover test strips; others will co-pay a specified amount depending on income. Ontario and Alberta provide a financial contribution of up to $550 a year for low-income people with diabetes to purchase their strips. Nova Scotia and New Brunswick are implementing similar programs to assist people with diabetes and low incomes in their provinces. As for Quebec, it reimburses partially the cost of test strips.

In almost all jurisdictions there are Canadians with diabetes struggling to purchase diabetes medications, devices and supplies, including test strips. Our 2005 Online Membership Survey revealed:

The majority of Canadians with diabetes pay out-of-pocket expenses

• Over one in two Association members (52 percent) reported that they pay for diabetes medications and supplies.
• More than 7 in 10 (72 percent) of Diabète Québec members pay out-of-pocket for medication and supplies.

Monthly out-of-pocket costs

• Almost one in two (46 percent) of Association members paying out-of-pocket expenses reported spending between $50 and $200 per month; 1 in 4 spent less than $50 a month.
• Among Diabète Québec members, 47 percent said they paid more than $50 a month but less than $200, while 36 percent paid less than $50 a month.

People with diabetes face financial limitations to purchasing drugs or supplies

• Almost 1 in 4 (24 percent) of Association members reported there were diabetes drugs, supplies or devices that their doctor recommended, but that they could not afford to purchase and could not access through their insurance plan.
• Those under age 40 living with type 1 diabetes were more likely to be unable to afford the diabetes medications and supplies recommended by their doctors.
• Only one in 10 Diabète Québec members reported there were drugs, supplies or devices they could not afford.
• Finally, 40 percent of Association members stated that their diabetes caused them or their family a financial hardship and that they were not covered by any health insurance plan, and were unaware of government financial assistance programs.
Diabetes health professionals developed the following two composite case studies to highlight the complexity and challenges of managing diabetes. Janet, a composite study of an individual with type 1 diabetes, was first introduced in the Diabetes Report Card 2001. Peter, with type 2 diabetes, was added in the Diabetes Progress Report 2003. For comparative purposes, both Janet and Peter’s circumstances are unchanged.

The Canadian Diabetes Association 2003 Clinical Practice Guidelines are the basis of the diabetes management treatments prescribed for both Janet and Peter. Their out-of-pocket costs were calculated from their specific prescriptions, including mark-ups and dispensing fees, as well any government programs (co-pays for example) for which they were eligible. These costs do not take into consideration the cost of living in each jurisdiction, nor are these costs the same for all Canadians living with either type 1 or type 2 diabetes.

Janet – Type 1 Diabetes Composite Case Study

For a person with type 1 diabetes, insulin is medically necessary to live. The 2003 Clinical Practice Guidelines recommend multiple daily injections (three to four per day) of insulin using a combination of rapid, intermediate, and/or long-acting insulin. Self-monitoring of blood glucose at least three times a day, eating healthy foods, regular physical activity, meal planning, carbohydrate counting, on-going tracking and monitoring of insulin dosage adjustments throughout the day are required. Janet’s story shows the coverage levels and costs someone with type 1 diabetes would face in different parts of Canada.

Janet is a 22 year-old woman with type 1 diabetes. She does not require additional medications to manage or avoid diabetes-related complications but may need to access them in future. Living alone with an annual income of less than $15,000 and no private health insurance plan, Janet relies solely on the assistance available from her federal, provincial or territorial government.

Janet takes four injections of insulin each day, three of rapid-acting insulin analogue and one of intermediate-acting insulin. To determine and adjust her insulin dosages, Janet must track and monitor her carbohydrate intake throughout the day.

In an attempt to improve her glycemic control and manage her A1C levels to target, Janet tests her blood glucose five times a day at different times including after meals. To check levels, Janet uses a lancet and lancing device to obtain a drop of blood. A blood glucose strip and a meter are used to read the result. If her blood glucose level is higher than 14 millimoles of glucose per litre of blood, Janet then uses ketone strips to check her urine for ketones, the waste products produced by the body that would indicate a potential medical emergency.

Janet’s diabetes healthcare team is considering starting her on an insulin pump to improve her glycemic control and improve her quality of life. While the pump would provide flexibility in her lifestyle and optimize her glucose control, she would be required to increase her blood glucose testing to between five and seven times per day.
Financial support available for Janet

Where Janet lives in Canada continues to play a major role in determining her access to supplies and medication and ultimately, how well she manages her diabetes.

As a low income working person in September 2005, Janet did not have coverage for any insulin in Nova Scotia, New Brunswick or Newfoundland and Labrador. Ontario, Nova Scotia, New Brunswick, Prince Edward Island and Newfoundland and Labrador did not cover the costs of syringes. In addition, no assistance was available for the cost of test strips in New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador. Yet if Janet had been on social assistance, she would have had access to coverage for insulin and syringes across the country.

### What Janet pays

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Annual out of pocket cost for prescribed medication &amp; supplies</th>
<th>% of Janet's annual income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland/Labrador</td>
<td>$3,639.33</td>
<td>25.1%</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>$3,585.71</td>
<td>24.7%</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>$3,355.42</td>
<td>23.1%</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>$3,116.19</td>
<td>21.5%</td>
</tr>
<tr>
<td>Alberta</td>
<td>$2,359.34</td>
<td>16.3%</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>$1,451.04</td>
<td>10.0%</td>
</tr>
<tr>
<td>Quebec</td>
<td>$962.85</td>
<td>6.6%</td>
</tr>
<tr>
<td>Ontario</td>
<td>$948.27</td>
<td>6.5%</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>$550.00</td>
<td>3.8%</td>
</tr>
<tr>
<td>British Columbia</td>
<td>$395.85</td>
<td>2.7%</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$336.40</td>
<td>2.3%</td>
</tr>
<tr>
<td>Yukon</td>
<td>$250.00</td>
<td>1.7%</td>
</tr>
<tr>
<td>Nunavut</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>NIHB (federal)</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Picture of what Janet pays annually**

![Bar chart showing annual out of pocket costs for prescribed medication and supplies across different jurisdictions in Canada.](image-url)
# Coverage Chart for Diabetes Supplies and Devices

If Janet lives in:

<table>
<thead>
<tr>
<th>Province</th>
<th>Costs Description</th>
<th>Emergency Assistance</th>
<th>Blood Glucose Strips and Ketone Strips</th>
<th>Lancets</th>
<th>Meter</th>
<th>Syringes/Pen Needles</th>
<th>Pumps and Pump Supplies</th>
<th>Insulin</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BRITISH COLUMBIA</strong></td>
<td>No deductible, 70% govt co-pay of prescription drug costs until Janet reaches a maximum of 2% of Net Family Income (NFI) – then 100% govt coverage.</td>
<td>Can apply for a “Medical Only File”. Requires financial assessment, doctor’s signature and situation must be life-threatening.</td>
<td>Blood glucose: Yes with a Training Certificate from a Diabetes Education Centre. Ketone: No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Pump: No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requests reviewed on a case-by-case basis.</td>
<td>Blood glucose: Yes (AMFH) Ketone: Yes (AMFH)</td>
<td>Yes: (AMFH)</td>
<td>No</td>
<td>Yes: (AMFH)</td>
<td>Pump: No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>ALBERTA</strong></td>
<td>Alberta Monitoring for Health (AMFH): eligible for $550/yr.</td>
<td>Requests reviewed on a case-by-case basis.</td>
<td>Blood glucose: Yes (AMFH) Ketone: Yes (AMFH)</td>
<td>Yes: (AMFH)</td>
<td>No</td>
<td>Yes: (AMFH)</td>
<td>Pump: No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One time annual emergency assistance may be available.</td>
<td>Blood glucose: Yes Ketone: Yes</td>
<td>Yes (if eligible for Special Support Program).</td>
<td>No</td>
<td>Yes (if eligible for Special Support Program).</td>
<td>Pump: No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>SASKATCHEWAN</strong></td>
<td>Janet may apply under the income-based Special Support Program, with deductibles based on 3.4% of adjusted family income. Co-payment rate is based on income &amp; benefit drug costs.</td>
<td>Not available.</td>
<td>Blood glucose: Yes to a max 4,000 strips per yr. Ketone: Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Pump: No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blood glucose: Yes to a max 4,000 strips per yr. Ketone: Yes</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Pump: No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Blood glucose: Yes (AMFH) Ketone: Yes (AMFH)
<table>
<thead>
<tr>
<th>COSTS</th>
<th>EMERGENCY ASSISTANCE</th>
<th>BLOOD GLUCOSE STRIPS and KETONE (urine test) STRIPS</th>
<th>LANCETS</th>
<th>METER</th>
<th>SYRINGES/ PEN NEEDLES</th>
<th>PUMPS and PUMP SUPPLIES</th>
<th>INSULIN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ONTARIO</strong></td>
<td></td>
<td>Blood glucose: Yes</td>
<td>Yes</td>
<td></td>
<td>Yes 65% or $74 every 5 yr.</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Trillium Program:</td>
<td></td>
<td>Ketone: No</td>
<td></td>
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<td>for low income &amp;</td>
<td></td>
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<td>high drug cost.</td>
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<td>Deductible based on</td>
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<td>doctor’s</td>
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</tr>
<tr>
<td>signature – 65%</td>
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<tr>
<td>govt co-pay to a</td>
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</tr>
<tr>
<td>max. $500/yr for</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>strips &amp; lancets.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Blood glucose: Yes</td>
<td>Yes</td>
<td></td>
<td>Yes 65% or $74 every 5 yr.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ketone: No</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>QUEBEC</strong></td>
<td></td>
<td>Blood glucose: Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Annual premium:</td>
<td></td>
<td>Ketone: Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>varies from $0 to $521</td>
<td></td>
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<td></td>
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<tr>
<td>depending on income.</td>
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<tr>
<td>Deductible: Up to</td>
<td></td>
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</tr>
<tr>
<td>$11.90/mo. Co-insurance: between 25% and 28.5% of drug costs to monthly max. of $71.42 depending on income.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Blood glucose: No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ketone: No</td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>NEW BRUNSWICK</strong></td>
<td></td>
<td>Blood glucose: No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>No coverage available</td>
<td></td>
<td>Ketone: No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(*Govt announced low income support program in 2005).</td>
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<td></td>
</tr>
<tr>
<td><strong>NOVA SCOTIA</strong></td>
<td></td>
<td>Blood glucose: No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>No coverage available</td>
<td></td>
<td>Ketone: No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(*Govt announced low income support program in 2005).</td>
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</tr>
</tbody>
</table>

If Janet lives in:
## If Janet lives in:

<table>
<thead>
<tr>
<th>Province/Region</th>
<th>Costs</th>
<th>EMERGENCY ASSISTANCE</th>
<th>BLOOD GLUCOSE STRIPS and KETONE (urine test) STRIPS</th>
<th>LANCETS</th>
<th>METER</th>
<th>SYRINGES/ PEN NEEDLES</th>
<th>PUMPS and PUMP SUPPLIES</th>
<th>INSULIN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prince Edward Island</strong></td>
<td></td>
<td>Register with Diabetes Control Program (DCP). Fee varies per Rx.</td>
<td>Some coverage for medical, supplies &amp; food depending on income &amp; living conditions.</td>
<td>Blood glucose: No</td>
<td>No</td>
<td>No</td>
<td>Pump: No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Newfoundland &amp; Labrador</strong></td>
<td></td>
<td>May be provided through Human Resources &amp; Employment.</td>
<td>Blood glucose: No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Pump: No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Nunavut</strong></td>
<td></td>
<td>Some financial, travel &amp; accommodation assistance available if necessary. Coverage of medical supplies &amp; equipment is available on case-by-case basis.</td>
<td>Blood glucose: Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Pump: Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Northwest Territories</strong></td>
<td></td>
<td>Not required.</td>
<td>Blood glucose: Yes to a max. 100 strips/mo with Rx.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Pump: Yes with special approval.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### If Janet lives in:

<table>
<thead>
<tr>
<th>Location</th>
<th>Costs</th>
<th>EMERGENCY ASSISTANCE</th>
<th>BLOOD GLUCOSE STRIPS and KETONE STRIPS</th>
<th>LANCETS</th>
<th>METER</th>
<th>SYRINGES/PEN NEEDLES</th>
<th>PUMPS and PUMP SUPPLIES</th>
<th>INSULIN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YUKON</strong></td>
<td>$250 deductible under Chronic Disease Program. 100% coverage of all costs.</td>
<td>Yes</td>
<td>Blood glucose: Yes  Ketone: Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes with specialist recommendation &amp; specific criteria met</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>NON-INSURED HEALTH BENEFITS (NIHB)</strong></td>
<td>Not required.</td>
<td></td>
<td>Blood glucose: Yes  Ketone: Exception status, reviewed on a case-by-case basis.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Pump: One every 5 years.  Supplies: Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If Janet were eligible for NIHB (as a registered Indian, an Innu member of a specified community or a recognized Inuk, resident in Canada), no deductible, no co-pay.
Peter – Type 2 Diabetes Composite Study

The Association’s 2003 Clinical Practice Guidelines recommend an aggressive approach to managing type 2 diabetes as soon as possible. For people with type 2 diabetes, it is recommended that blood glucose levels be tested at least once a day. Physicians are also advised to begin pharmacologic intervention within two to three months of diagnosis if the recommended glycemic target of 7 percent or lower cannot be reached using lifestyle management, including diet and exercise. The 2003 Clinical Practice Guidelines also recommend greater attention to preventing and treating cardiovascular complications and dyslipidemia. Peter’s story below shows the coverage levels and costs someone with type 2 diabetes would face in different parts of Canada.

Peter is 52 years-old and self-employed. He was diagnosed with type 2 diabetes in 2003. He and his wife, Mary, have no private health insurance plan. Mary works full-time and earns $25,000 a year, while Peter earns $30,000 per year. Peter relies solely on what is available from the federal, provincial or territorial government for his diabetes medications and supplies. To manage his diabetes effectively and help prevent serious complications, Peter needs ongoing diabetes education to teach him how to manage all aspects of his type 2 diabetes.

Peter takes two anti-hyperglycemic oral medications to achieve required blood glucose levels. He may need to add insulin to his treatment program in the future. As well, Peter takes two antihypertensive medications to regulate his blood pressure, one of them an angiotensin converting enzyme (ACE) inhibitor to protect his kidneys from complications. He uses a statin to lower lipids. Peter maintains a healthy diet and exercises regularly. He takes a low dose aspirin (ASA) tablet daily for anti-platelet therapy and tests his blood glucose twice a day.

Peter faces similar obstacles to Janet in obtaining financial coverage. The recommendation for more aggressive management of his diabetes requires Peter to take multiple therapies and additional medications to prevent heart disease, stroke and kidney disease.

Financial support available for Peter

Like Janet, Peter’s ability to manage his disease also depends on where he lives in Canada.

As a middle-income, self-employed person with type 2 diabetes in 2005, Peter was not eligible for financial assistance for his test strips, lancets, or oral medications in Newfoundland and Labrador, Prince Edward Island, Alberta, Ontario, Nova Scotia and New Brunswick. He did not qualify for financial assistance programs geared to low income people or seniors.
### What Peter pays

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Annual out of pocket cost for prescribed medication &amp; supplies</th>
<th>% of Peter’s annual income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland/Labrador</td>
<td>$ 3,894.68</td>
<td>13.0 %</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>$ 3,674.03</td>
<td>12.3 %</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>$ 3,441.83</td>
<td>11.5 %</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>$ 3,225.36</td>
<td>10.8 %</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>$ 2,225.70</td>
<td>7.4 %</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$ 2,224.15</td>
<td>7.4 %</td>
</tr>
<tr>
<td>Ontario</td>
<td>$ 2,046.49</td>
<td>6.8 %</td>
</tr>
<tr>
<td>British Columbia</td>
<td>$ 1,897.49</td>
<td>6.3 %</td>
</tr>
<tr>
<td>Alberta</td>
<td>$ 1,733.61</td>
<td>5.8 %</td>
</tr>
<tr>
<td>Quebec</td>
<td>$ 1,460.49</td>
<td>4.9 %</td>
</tr>
<tr>
<td>Yukon</td>
<td>$ 290.15</td>
<td>1.0 %</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>$ 40.15</td>
<td>0.1 %</td>
</tr>
<tr>
<td>Nunavut</td>
<td>$ 40.15</td>
<td>0.1 %</td>
</tr>
<tr>
<td>NIHB (federal)</td>
<td>$ 40.15</td>
<td>0.1 %</td>
</tr>
</tbody>
</table>

**Picture of what Peter pays annually**

- **BC**: 3500
- **AB**: 3000
- **SK**: 2500
- **MB**: 2000
- **ON**: 1500
- **QC**: 1000
- **NB**: 500
- **NS**: 500
- **PEI**: 500
- **NL**: 500
- **YK**: 500
- **NT**: 500
- **NU**: 500
# Coverage Chart for Diabetes Supplies and Devices

<table>
<thead>
<tr>
<th>If Peter lives in:</th>
<th>COSTS</th>
<th>EMERGENCY ASSISTANCE</th>
<th>BLOOD GLUCOSE STRIPS and KETONE (urine test) STRIPS</th>
<th>LANCETS</th>
<th>METER</th>
<th>ORAL MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BRITISH COLUMBIA</strong>&lt;br&gt;Deductible: 3% of Net Family Income (NFI). 70% govt co-pay of prescription drug costs until Peter reaches a max of 4% of NFI – then 100% govt coverage.</td>
<td>Can apply for a “Medical Only File”.</td>
<td><strong>Blood glucose:</strong> Yes – with a training certificate from a Diabetes Education Centre.&lt;br&gt;<strong>Ketone:</strong> No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>ALBERTA</strong>&lt;br&gt;Alberta Blue Cross family quarterly premium $123. 70% govt co-pay to a max of $25,000 per year. Peter pays 30% up to $25 per Rx.</td>
<td>Requests reviewed on an individual basis.</td>
<td><strong>Blood glucose:</strong> No&lt;br&gt;<strong>Ketone:</strong> No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>SASKATCHEWAN</strong>&lt;br&gt;Peter may apply under the income-based Special Support Program, with deductibles based on 3.4% of adjusted family income. Co-pay rate is based on income &amp; benefit drug costs.</td>
<td>One time annual emergency assistance may be available.</td>
<td><strong>Blood glucose:</strong> Yes&lt;br&gt;<strong>Ketone:</strong> Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>MANITOBA</strong>&lt;br&gt;Deductible: 4.20% of Peter's adjusted family income (when AFI is &gt;$40,000/yr &amp; &lt;/or equal to $75,000/yr).</td>
<td>Not available.</td>
<td><strong>Blood glucose:</strong> Yes to a max 4,000 strips per yr.&lt;br&gt;<strong>Ketone:</strong> Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

**Blood glucose:** Yes – with a training certificate from a Diabetes Education Centre.
<table>
<thead>
<tr>
<th>Province</th>
<th>Costs</th>
<th>Emergency Assistance</th>
<th>Blood Glucose Strips and Ketone (urine test) Strips</th>
<th>Lancets</th>
<th>Meter</th>
<th>Oral Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ontario</strong></td>
<td>Trillium Program: for low income &amp; high drug cost. Deductible based on income, $2 fee per Rx.</td>
<td>Not available.</td>
<td>Blood glucose: No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ketone: Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Quebec</strong></td>
<td>Annual premium: varies from $0 to $521 depending on income. Deductible: Up to $11.90/mo. Co-insurance: between 25% and 28.5% of drug costs to monthly max. of $71.42 depending on income.</td>
<td>Not available.</td>
<td>Blood glucose: Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ketone: Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>New Brunswick</strong></td>
<td>No coverage available.</td>
<td>Not available.</td>
<td>Blood glucose: No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ketone: No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nova Scotia</strong></td>
<td>No coverage available.</td>
<td>Potential eligibility under Community Services Program. Special Needs if no assistance available from other sources.</td>
<td>Blood glucose: No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ketone: No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prince Edward Island</strong></td>
<td>Register with Diabetes Control Program (DCP). Fee varies per Rx.</td>
<td>Some coverage for medical, supplies &amp; food depending on income &amp; living conditions.</td>
<td>Blood glucose: No</td>
<td>No</td>
<td>No</td>
<td>Yes if registered with DCP.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ketone: Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COSTS</td>
<td>EMERGENCY ASSISTANCE</td>
<td>BLOOD GLUCOSE STRIPS and KETONE (urine test) STRIPS</td>
<td>LANCETS</td>
<td>METER</td>
<td>ORAL MEDICATIONS</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>----------------------</td>
<td>---------------------------------------------------</td>
<td>---------</td>
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<td>-----------------</td>
<td></td>
</tr>
</tbody>
</table>
| **NEWFOUNDLAND & LABRADOR**  
No coverage available. | May be provided through Human Resources & Employment. | Blood glucose: No  
Ketone: No | No | No | No |
| **NUNAVUT**  
Extended Health Benefits Program: no deductible & no co-pay. | Some financial, travel & accommodation assistance available if necessary.  
Coverage of medical supplies & equipment is available on a case-by-case basis. | Blood glucose: Yes  
Ketone: Yes | Yes | Yes | Yes |
| **NORTHWEST TERRITORIES**  
No deductible, no co-pay. | Not required. Some medical supplies & equipment can be covered with special authorization. | Blood glucose: Yes to a max. 100 strips/mo with Rx.  
Ketone: Yes | Yes | Yes | Yes |
| **YUKON**  
$250 deductible per person; $500 per family, then 100% coverage. | Deductible may be waived in case of hardship. | Blood glucose: Yes  
Ketone: Yes | Yes | Yes | Yes |
| **NON-INSURED HEALTH BENEFITS (NIHB)**  
If Peter were eligible for NIHB (as a resident of Canada & a registered Indian, an Innu member of a specified community or a recognized Inuk), no deductible, no co-pay. | Not required. | Blood glucose: Yes  
Ketone: Yes | Yes | Yes | Yes |

If Peter lives in:
In this section the profiles of 28 Canadians with diabetes are presented. Canadians speak about the reality of living with diabetes in every province and territory.

**Barb Marche & Liam Marche, 8**  
*Red Brook, Newfoundland & Labrador*  
Although some of the costs of Liam’s diabetes medication and supplies are offset through a private insurance, his parents pay about $450 a month out of pocket for his pump supplies and related needs. They covered the $6,000 cost of his insulin pump and will pay for a replacement every four years.  

Barb describes managing Liam’s diabetes as a “24-hour a day job with no respite.” Testing his blood glucose, logging and analyzing trends to make changes to insulin dosages in order to maintain the tightest control possible to help Liam avoid serious complications later in life is a full-time job.  

“There should be support and protection in the schools for children with diabetes,” she says. “We must convince educators that diabetes is a life-threatening condition requiring constant attention. Working with teachers to ensure timely testing, injection and supervision of meals at school is essential.”  

“When you live with diabetes, you take nothing for granted,” says Barb. “When you think you have it figured out, diabetes does something out of the ordinary and you are back to square one. When you have battled a week of lows and made adjustments that leave your child in his glycemic range, it will only last a few days and then you will be back to battling highs.”

---

**Mary Ellen Wright**  
*St. John’s, Newfoundland & Labrador*  
Mary Ellen, a widow and mother with three children, works full-time earning between $30,000 and $45,000 a year. Diagnosed with type 2 diabetes in 2002, she struggles financially to manage her disease while meeting her many family obligations.  

“It happens all the time,” Mary Ellen says. “I usually juggle my medication to stretch it out a little farther, and am not testing often enough, so my diabetes is not at all well-regulated.”

Her drugs, including insulin, medication for high blood pressure, regulating thyroid and cholesterol and diabetes-related supplies are too expensive for her. Mary Ellen gets no financial support from the province, has no private insurance and spends over $250 a month out-of-pocket to buy her medications and supplies.

Mary Ellen worries about not managing her diabetes properly and acknowledges the risks of not testing her blood glucose as often as required. She knows she should test her blood glucose level six times a day, but that would mean spending $180 a month on test strips. “I can’t afford it, so I only test once or twice a day – if that.”

Frequently, she does not take her prescribed medications because she cannot afford them, putting herself at serious risk of complications.

“It is especially a problem in the winter, when heating costs are high; the power bill has to come first, then groceries, then my diabetes medications, then school costs and other children’s necessities, then my testing supplies. Other medical expenses like dental care and glasses for me are not on the list at all!”

---

**Reality Check:** Canadians with Diabetes Speak Out
Florence Flynn, 63  
Cornwall, PEI

“Because I’ve had diabetes for so many years I’m at high risk for complications and require careful management,” says Florence, who has had type 1 diabetes since she was nine years old. She has arthritis and neuropathy in her left foot. She had cataract surgery in 1989. Florence needed surgery last summer to correct bleeding in the back of one eye.

“I was able to go on the insulin pump which gives me a lot more freedom and control. I wish I’d gone on it sooner,” Florence says.

The complications of her diabetes requires more medical attention. “The only endocrinologist in the province left and most family physicians don’t know enough about diabetes,” says Florence. “I have to go to Saint John, New Brunswick, to see my endocrinologist now, but I’m prepared to do that. He has supported me going on an insulin pump.”

Because of her husband’s drug plan at work, the costs of the insulin pump and its $300 a month supplies are paid for, as are the diabetes medications and supplies needed to manage his type 2 diabetes. Florence must also pay for test strips out of her own pocket. Her husband wants to retire. But, if he does, they would lose his employment drug and health insurance coverage and would personally need to pay more than $3,000 a year to manage her diabetes as prescribed by her physician.

Olive Bryanton, 68  
Charlottetown, PEI

“With diabetes, it costs more to eat healthy and that affects many older people on fixed incomes. Although I am a senior, I still work. If I was not working I would have difficulty maintaining a healthy lifestyle and meeting my medication and diabetic needs,” says Olive, who was diagnosed with type 2 diabetes in 2003. Olive works part-time and has an annual income of less than $30,000.

Having the financial resources to manage her diabetes is a constant worry for Olive. Olive is on cholesterol and blood pressure medications along with low dose aspirin that her doctor prescribed as a precaution against diabetes complications. Although Olive receives some assistance from the province for her diabetes medications, she still spends more than $100 a month out of her own pocket for diabetes medications, supplies and other medications.

Olive tests her blood glucose three to five times a day and occasionally at other times during the month. She pays almost $75 for 100 glucose strips. “If I needed to use the strips more often, I would find it a challenge to afford them.” If the cost of living, or if the cost of her medications increase, or if serious complications occur, Olive could face serious financial hardship and some very difficult choices. “People on fixed incomes are in jeopardy when it comes to making decisions about whether to buy their medication or cut back so their medication lasts longer,” she says.
Tami Publicover, 31  
*Halifax, Nova Scotia*

As a student Tami went on social assistance in order to cover most of the cost of her diabetes supplies and medications. Her annual income is less than $10,000. She spends about $85 a month out-of-pocket for one of her insulin medications because it is not listed on the provincial drug formulary.

“When I had to leave my job for health reasons and decided to go back to school, I tried to obtain health coverage for my insulin and testing supplies but it was too expensive and I was forced to apply for social assistance,” recalls Tami, who was diagnosed with type 1 diabetes at age seven.

“The first year I was a student, before going on social assistance, I was purchasing test strips and needles rather than healthy food…but I did take care of my diabetes.”

While social assistance has helped cover the costs of Tami’s medications and supplies, buying healthy food has always been difficult.

“It was important for me to find ways to care for my diabetes by eating healthy and managing a very tight budget, Tami says. “Fresh fruit, vegetables and bread are sometimes not possible so resorting to cheap and canned or frozen food has been my option because the social assistance allowance for people with diabetes is not enough.”

Tami also faces health challenges in managing her diabetes. She has immune system problems and is very susceptible to colds, flu, pneumonia and bronchitis.

“I would like to be on an insulin pump and I need my long acting insulin to be covered by the provincial drug program,” she says. A pump is about $6,200 and requires supplies costing about $250 a month.

Betty S., 62  
*Cape Breton, Nova Scotia*

“I didn’t ask for this disease and I don’t understand why more can’t be done for low income people living with it,” says Betty, a retired widow with type 2 diabetes. “People who know me know that I don’t drink and I don’t smoke and I eat as healthy as I can and they know I try to take care of myself.”

Betty receives a widow’s allowance and has a net annual income of about $12,000. She will have no drug coverage until she turns 65. When first diagnosed, Betty was able to control her diabetes with oral medications and diet. After 10 years, her blood glucose levels kept rising and she developed neuropathy in both legs. Her doctor prescribed insulin to bring her glucose levels back into the target range. Today, she takes two insulin injections each day.

Blood glucose test strips are too expensive for her, so she checks her levels only twice a day. “If I could afford the test strips, I’d test more,” she says.

“Diabetes is a severe financial burden for me. I am not eligible for any support and I have to pay for everything myself,” says Betty. “To get support from the provincial drug plan I have to be 65. Until then I have to pay almost $300 a month for my diabetes supplies.”
Kathy A., 33  
*Fredericton, New Brunswick*

Kathy has type 1 diabetes and for years she struggled to overcome financial challenges to pay for her diabetes supplies and medications. She often cut back on testing her blood glucose levels because of the cost of test strips.

“I was taking just two insulin injections a day and I was very restricted in what I could do. If people aren’t testing they can’t make choices – choosing how active you’re going to be, what you’re going to eat and when, what activities you’re going to participate in,” she says.

Since 1998, Kathy’s employer provides a drug plan that pays for most of her diabetes supplies.

However, she has experienced some difficulty in obtaining appropriate medical attention. After huge fluctuations in her blood glucose levels, she developed kidney problems. It wasn’t until she was referred to a new endocrinologist and received intensive therapy and access to a diabetes care team that her condition improved.

“Sometimes I get very angry that I developed kidney problems because I wasn’t getting the proper support,” Kathy says, “but I’ve decided that I can’t do anything about that now except try to take better care of myself in the future.”

Brice Forsyth, 48  
*St. John, New Brunswick*

“Right now, I’m not taking my insulin because I can’t afford it. I can’t afford to get my blood glucose tested. I used to be able to get free strips from the diabetes educators but they don’t get strips donated to them any more,” says Brice who was diagnosed with type 2 diabetes in 2003.

Brice receives a small disability pension and his annual income is less than $15,000. His financial situation severely limits his ability to manage his diabetes, putting him at risk of serious complications. He is waiting to find out if he qualifies for New Brunswick’s recently announced program to assist low-income people with buying their diabetes medications and supplies.

Brice should take two injections of insulin each day, once in the morning and once at night before supper. In New Brunswick, the provincial government does not provide insulin, test strips or needles.

“If I were taking proper care of myself, I’d have to spend at least $300 per month of my own money for my diabetes supplies and medications, nearly $200 per month for strips alone,” he says.

“I can’t afford test strips so I don’t know what my blood glucose levels are,” he says. “I have two choices. I can live on the street and pay for my diabetes supplies. Or I can pay my rent and my bills and not take care of my diabetes. To live better, I need the cost of my strips, needles and lancets covered.”
Robert Bacon, 48
Terrebonne, Quebec

“It’s hard to find the money to pay for your diabetes supplies. I try to test four to five times a day but sometimes I test only twice a day to save money,” says Robert Bacon, a sales representative diagnosed with type 1 diabetes in 2002.

“I take rapid-acting insulin three times a day and long-acting insulin at night. I test my blood glucose at least four times a day. My doctor prescribed a cholesterol lowering medication but I don’t take it as it is too expensive.”

Even with his medication costs reduced through his private insurance plan, Robert needs to pay personally for some medication and supplies. The expense of managing diabetes affects Robert and his family who find it challenging to make ends meet.

“My private plan only covers 80 percent of the total costs,” he says. “Because I have a private plan I don’t get any support from the government drug plan. I pay deductibles on my private plan. Blood glucose strips cost a lot and it’s a problem affording them. Diabetes costs me about $320 a month.”

Laurel M., 30
Toronto, Ontario

“Sometimes it just feels like you are so alone in managing your diabetes,” says Laurel, “It never goes away and I deal with it, 24 hours a day, seven days a week.”

Laurel is a student and was diagnosed with type 1 diabetes at age 10. Employed part time and earning only $15,000 a year, Laurel faces significant hardship in covering the cost of managing her diabetes.

Laurel has limited assistance for supplies for her insulin pump that she views as a lifeline that keeps her healthy. Although she gets some benefits through a private drug plan, Laurel still pays more than $125 a month out-of-pocket for test strips and pump supplies. To keep costs down, Laurel stretches her money by re-using supplies such as lancets. She recently paid $800 to upgrade her insulin pump.
“It is always in the back of my mind that the cost of my diabetes supplies is very high,” she says. “At all times there is a fear that I will not be able to continue to manage my diabetes with my insulin pump due to the cost.”

Laurel tries to find jobs that provide coverage for diabetes supplies “because the government offers minimal assistance.” Laurel worries about not being able to afford her insulin pump supplies because of the costs and then developing complications because she would not be able to control her blood glucose levels.

“I am afraid of not having a job where my pump supplies are covered. It makes such a huge difference in my diabetes control that I cannot imagine living without it.”

**Ramnik Shah, 60**
*Oakville, Ontario*

Ramnik has been able to manage his type 2 diabetes since it was discovered five years ago. Retired with a private drug plan, he carefully follows his physician’s advice.

“When I was diagnosed with diabetes, it was a wake-up call,” he recalls. “I adjusted my diet significantly and increased my physical activities such as walking and cycling. Overall, while I have the illness, I am feeling healthy.”

He regularly tests his blood glucose levels and takes medication to control hypertension and his cholesterol levels that can contribute to heart-related complications. Ramnik says, “I was disturbed to learn that my blood pressure and cholesterol levels had to be lower than they would be in a normal healthy person so I reluctantly started medications for those conditions.”

“While the cost of the medication for managing diabetes, as well as associated hypertension and cholesterol, does not have a major financial impact on me,” Ramnik says, “I know that those without adequate drug coverage would find it difficult to pay for these expensive medications and devices. The financial burden might force those people to forgo proper diabetes management, risking serious consequences.”

**Gary Blaseg, 54**
*Sudbury, Ontario*

“Diabetes is the quiet killer. You don’t know what it’s doing to you, usually, until it’s too late.”

More than 40 years ago Gary was diagnosed with type 1 diabetes. At 16 he began multiple injections of insulin. The serious complications associated with diabetes eventually began. In 1991, Gary had kidney failure and needed a kidney transplant. Later, he lost an eye because of diabetic retinopathy, and three years ago he lost a leg due to nerve damage.

Gary’s provincial drug plan covers 80 percent of the costs of some of his diabetes medications and supplies. However, he still pays about $175 a month out-of-pocket for the medications and supplies that his doctor recommends but which are not on the formulary.

“It’s not easy living with diabetes, there are always restrictions. You tend to not tell people that you have diabetes because you’re ashamed
of it. I felt that people, if they knew, wouldn’t treat me as an equal
and I wouldn’t get jobs,” he says.

Dave Speer, 64
Rossport, Ontario

“When I was diagnosed I had all kinds of
symptoms – blindness, terrible thirst, hyper-
tension, tingling in my feet. The symptoms were
probably there for years before I was diagnosed.
At the time, I thought I was dying.”

Since being diagnosed with type 2 diabetes in 1988, Dave has
developed serious complications. Dave recently underwent
quadruple bypass heart surgery and has neuropathy.

Dave lives on a disability pension. His income is too high to qualify for
assistance from Ontario’s Trillium drug benefit program. To visit his
endocrinologist and other specialists regularly he travels 200
kilometres to Thunder Bay at his own expense.

“My diabetes supplies and medications cost me approximately $200 per
month and my other medications cost me another $100 per month.”

Carissa Nikkel, 21
Winnipeg, Manitoba

“When I was diagnosed with diabetes, it
presented me with a lot of new obstacles and
challenges to overcome,” says Carissa, a student
with type 1 diabetes since age seven. “But it was put into perspective
for me when I was told that it was a disease, unlike others, that you
can manage and control.”

Gaining control of her diabetes has been a challenge for Carissa. In
addition to having diabetes, Carissa has celiac disease. She had her
pancreas removed after years of chronic pancreatitis. She earns $15,000
annually. She uses a lot of medications and supplies and worries about
her ability to afford them when she is no longer a student. Carrissa
currently pays the first $300 of her prescription drugs and diabetes
supplies, and then Manitoba Pharmacare covers the rest.

“Because my income is so low and the provincial program covers most
of my costs, I’m okay right now,” she says. “I’m worried about what
will happen when I’m making just enough money that I won’t qualify
for as much help from the government plan.”

“I have ongoing problems with unexplained hypoglycemia and varying
blood sugars. Celiac disease complicates the dietary issues I have to
manage because of my diabetes.”

“I value every opportunity to talk with others with diabetes because I
learn from them and that helps me manage my disease, she says.
“Diabetes does make my life more difficult… but it is manageable and
it’s important to try to beat it!”
Harlene McPherson, 67  
*Brandon, Manitoba*

Harlene, who was diagnosed with type 2 diabetes in 1996, strives to balance her activity level with her insulin requirements and keep her blood glucose tightly controlled. In the first year, Harlene maintained good control of her diabetes with diet and exercise. Then, in 1997, she was diagnosed with breast cancer. Her blood glucose levels went very high and stayed high. Ever since, Harlene has been on multiple injections of insulin.

While private insurance covers 80 percent of the cost for all her diabetes supplies, Harlene pays the remaining 20 percent until she reaches her deductible under Manitoba’s Pharmacare program. That usually happens by the last month of the year so she receives very little support from the government.

“In addition to my drugs and diabetes supplies, I need to eat healthy food and that costs a lot more,” she says. “But I pay more because I want to stay healthy. I don’t think the government understands that this is an additional cost of managing diabetes.”

“I have a wonderful family physician I see four times a year. I also see a dietitian, diabetes nurse educator, an optometrist each year as well as an endocrinologist if I need to. I wish that my diabetes care team was all under one roof...like a clearing house or a centre for diabetes care. Keeping them informed of my disease is challenging. It takes a great deal of my time, but is paramount for prevention of complications and treatment.”

“I manage my own condition and make sure my health care team is informed. One person in my health care team should be collecting information on my diabetes and have it in one place, so that all aspects of my diabetes and my health are considered,” she adds. “Here in Brandon we do not have an endocrinologist, which is an integral part of a diabetes health care team. I feel we should have one!”

Sue Denison, 41  
*Rankin Inlet, Nunavut*

Sue is disciplined about following her type 1 diabetes management regime since being diagnosed in 1992. A key support is the coverage from her Nunavut government sponsored drug plan. It provides 80 percent of the costs of her medications and supplies and helps offset potential financial hardships in managing her condition.

Sue’s regime includes insulin, medications for hypothyroidism, potassium levels and blood pressure and testing for blood glucose levels up to five times daily. The drug benefit program together with a stable family income enables Sue to follow her regime and manage her diabetes aggressively to prevent complications.

“I have no complications at present, but I am told that I am at risk for eye problems, heart disease, stroke, kidney, leg and foot problems.”

The isolation of living in a remote part of Canada is an added challenge. Sometimes it takes awhile to get supplies because of the location. The cost of food, shelter and travel adds to the pressure of managing her diabetes.
“Even though I make a decent living, things are very expensive…$16 for four litres of milk, $20 for 10 pounds of potatoes…I am supposed to eat a healthy diet of fresh vegetables, but a cucumber is $6.99…”

Jonah Kilabuk, 52  
Pangnirtung, Nunavut

“I never paid much attention to diabetes until I was diagnosed. It was hard to accept that I had diabetes and I was scared when I heard about its complications,” recalls Jonah, a translator and researcher who learned three years ago that he had type 2 diabetes.

Today, Jonah follows a prescribed diabetes management plan and has the added challenge of living in a remote northern community. All of Jonah’s medication costs are covered by the Nunavut government drug plan.

“I take a number of medications to prevent damage to my kidneys and heart,” he says. “I also take a cholesterol lowering medication and I test my blood three times a day and eat carefully.”

He sees his family physician every six months. He needs access to a dietitian and because his family is his primary diabetes support network, Jonah would like his wife to get diabetes education.

Jonah is worried about the rise of diabetes in Nunavut. “I speak English and can get information from the Internet, but a lot of people here are unilingual and only speak their native language. There’s a lack of public information about diabetes available. I tell people what it’s like to live with diabetes and I encourage them to take care of themselves. But I can’t do this all the time because I have to work to survive.”

Laurel Jungwirth, 33  
Humbolt, Saskatchewan

“I probably suffer most from a degree of hypoglycemic unawareness,” says Laurel. “At times I do not feel the symptoms of a low sugar, yet on another day I will.” Once a co-worker assisted Laurel in treating her low blood glucose.

Laurel is a diabetes educator diagnosed with type 1 diabetes in 1979 at age seven. She realizes that it affects every aspect of her daily living.

“I always test my blood sugar before I drive a car and I don’t go far without more testing. Two or three times a week I wake myself up during the night to make sure that I’m not too low.”

She takes intermediate-acting insulin twice daily and and rapid-acting insulin with meals. In addition, Laurel tests her blood glucose levels four to six times a day and when sick, she tests more.

Laurel gets financial support for her diabetes supplies and medications from both the Saskatchewan Drug Benefits Plan and her workplace plan. Before having this support, Laurel spent more than $5,000 annually for medications and supplies.

Even with the drug plans, Laurel faces barriers to better care. Laurel would like to go on an insulin pump to improve her diabetes control. But pumps cost more than $6,000 and are not covered by either of her drug plans and she cannot afford to buy one. “I’d also like to try long acting insulin to help deal with night-time lows but until it’s listed on the drug plan I can’t afford it.”
“When I think of all of the money that I’ve spent for diabetes medication over the years,” Laurel says, “I could have been able to save a lot for my retirement.”

Mel Cheavins, 68
Yorkton, Saskatchewan

“Before I was diagnosed with type 2 diabetes in 1995, I had lost all of my energy,” Mel recalls. “After I was diagnosed I had a lot of trouble getting my blood glucose within the normal range. I exercised, dieted and lost 30 pounds but I still didn’t have any energy.”

Working with his doctor, Mel made changes to his insulin program that improved his blood glucose levels. He manages carefully, but getting his diabetes under control is difficult. Mel tests his blood glucose once a day and takes heart medication.

With an RCMP pension and benefits including a drug plan, Mel does not deal with the financial burden that many do. Looking back on his experience with diabetes so far, Mel observes, “There are still a lot of doctors who are telling people they have ‘border-line diabetes’ when their blood sugar readings are over seven. And that needs to change.”

Mel tells people who are newly diagnosed, “Take care of yourself because if you don’t you’ll create a lot of problems for yourself and your family.”

Todd Janes, 35
Edmonton, Alberta

Todd was diagnosed with type 1 diabetes at age nine. Employed by a not-for-profit arts organization, he makes between $30,000 and $45,000 per year. The financial costs of diabetes are a burden for Todd.

“I take multiple injections of fast-acting insulin every day, I take long-acting insulin daily, a calcium metabolizer and other drugs from time to time. On a day when I’m feeling well, I test four or five times a day – when I’m not feeling well, I test about 10 times a day. I have limited prescription drug coverage. I only get 80 percent of my prescription drug costs covered up to $500 per year.”

“The Monitoring for Health Program in Alberta is means tested and the coverage is very low. Living with a chronic disease stigmatizes you. Having to show your financial records to prove you need help is degrading. My diabetes care costs me a lot of money, but I live alone and I make the lifestyle choices I need to take care of myself,” Todd says. “I’d like an insulin pump, but it’s very expensive.”

Access to the right medical support is critical for Todd to manage his diabetes. Today, he has diabetes complications: neuropathy in both feet and laser surgery on both eyes due to diabetic retinopathy. Being without a family physician, Todd relies on an internist as his primary physician.

“I have an ophthalmologist and dietitian, a physiotherapist and an optometrist. I don’t have a social worker to advocate for me now and I don’t have a psychiatrist,” he says. “We need to look at different models for multi-disciplinary practice, which is especially important for diabetes.”
Bob Serne, 68  
Edmonton, Alberta

Now retired, Bob was diagnosed with type 2 diabetes in 1986. He takes insulin six or seven times a day and tests his blood glucose levels four or five times a day. His diabetes supplies and medications cost him $1,500 per year over and above the assistance he receives from Alberta Monitoring for Health and insurance. He has other health problems that add to his costs for medications.

Bob is concerned about cuts to diabetes education and health team programs. “We had a strong program that has been cut back so there’s no longer the same incentive to manage your diabetes well,” he says. “You’d be called back to see the same team every six months, but now follow up is with the family doctor. I see my doctor once a year and that’s not enough,” he says. “A family doctor hasn’t the time and is not focused enough on diabetes to give you the same support as that of a diabetes health team.”

Alex M., 23  
Yellowknife, Northwest Territories

“I know for a lot of people having diabetes can be very difficult. I went to school with a guy who has type 1 diabetes and he is going to die soon because he takes such terrible care of himself. He can barely see and his kidneys are failing,” says Alex who wonders how people can let themselves go like that. Alex was diagnosed with type 1 diabetes at the age of eight, and thanks to his parents’ drug plan and the NWT drug plan, his diabetes medications and supplies are fully covered.

Alex will be switching soon to long lasting insulin that is being listed on the NWT formulary.

“I have been fairly lucky,” he says. “I’ve had a few hypoglycemic reactions since I was diagnosed. Once I was sick and became dehydrated and had to be hospitalized to get my blood sugar down.”

Jerry Loomis, 63  
Norman Wells, Northwest Territories

“Getting diabetes meant that I had to change my life. I had to work less and pay more attention to my health,” says Jerry. “My doctor scared me: lose weight, control your blood glucose or you will not be here in a year!”

Jerry, a successful businessman, was diagnosed with type 2 diabetes in 2000 at the age of 58. Today, he controls his diabetes through medication, diet and exercise.

Fortunately for Jerry, all of his diabetes supplies are covered 100 percent through insurance and the NWT drug plan. These benefits, together with his successful businesses mean the cost of medications and supplies is not an issue for Jerry and his family.

Jerry believes that access to nutritious food is important to preventing diabetes in the north. “The stores primarily stock junk food. The cost of pop and alcohol are the same as in the south, but the cost of fresh, nutritious food is prohibitive. For those of us who can afford it, the answer is ‘food mail’. We order fresh food from grocery
stores in Yellowknife or Edmonton and Canada Post flies it into our communities. On a recent order of 16 kilograms of fresh food, the freight charges were $61.41. If the same shipment had been sent by ‘food mail’, the cost would have been $12.80.”

“But low income families with diabetes cannot use food mail because they don’t usually have credit cards,” Jerry says.

**Chris Laird, 61**  
**Vancouver, British Columbia**

Chris is unemployed and lives on social assistance receiving about $11,000 a year. He faces severe hardships in managing his type 1 diabetes that was diagnosed nine years ago. He especially worries about how to eat properly when his money runs out at the end of the month.

Chris says that running out of money “causes me not to take my insulin for the last five to seven days of the month. It plays havoc with my diabetes control.”

By being unable to keep his blood glucose levels at target level, Chris is at high risk for complications, and is concerned about neuropathy in his legs, bladder and bowels. He has been hospitalized twice for episodes of diabetic ketoacidosis, the consequence of severe, out-of-control diabetes. Also critical to Chris is his ability to get support from a diabetes healthcare team. He has no family doctor, but he has a dietitian, diabetes educator or endocrinologist to help him manage his diabetes more effectively at the St. Paul’s Diabetes Clinic.

“I would like to be on the insulin pump to give me better control of my diabetes, but it is not covered by the provincial drug plan, and I can’t afford to get one,” he says.

**Jamie Waterlow, 24**  
**Vancouver, British Columbia**

“As a teenager the biggest problem was that I didn’t always take care of myself,” says Jamie in describing his life with diabetes. “My blood sugars were up and down and I wasn’t in good control for about four years. Gaining and maintaining control is still a challenge…I have had a weight problem and when I’m overweight I have real problems.”

Jamie has lived with type 2 diabetes since 1995. He works full-time earning less than $30,000 a year. Besides the diabetes medications that are covered by BC Pharmacare, Jamie’s doctors have also prescribed two insulins that are not covered by the provincial plan. Jamie needs to pay $185 each month out of his own pocket. Other costs such as corrective footwear to help reduce Jamie’s risk of foot injury, annual Medic-Alert fees, podiatry visits, and over the counter skin lotions all add up each month. Because he lives with his parents, Jamie is not faced with the financial burdens experienced by many with diabetes, though the costs still place a pressure on his family’s budget.

Like all young adults, Jamie looks forward to moving out on his own, but he worries about his ability to pay for his diabetes medications and supplies. He believes that the cost of managing his diabetes has strongly impacted his independence and ability to be self-supporting. Jamie
takes daily insulin injections and oral medications. He tests his blood glucose three or four times daily. He sees his endocrinologist twice a year and has annual meetings with a dietitian and diabetes educator.

Sometimes he stretches the time between his glucose blood testings. “I know I have sometimes tested less because it’s so expensive. I would like to test more but, at a buck a piece, test strips are so expensive,” he says.

Araica McPhee, 30
Whitehorse, Yukon
Araica has type 1 diabetes which was diagnosed in 1998. She and her husband moved to the Yukon from BC to get the better financial support for people with diabetes provided by the territory. Yukon Health covers the costs of her insulin pump and that gives her better control of her diabetes.

“In BC, I didn’t have the same coverage and I was trying to pay for most of my diabetes medications and supplies myself. Many times I had to choose between test strips and bread,” says Araica. “The Yukon is much better. Their chronic care program covers my costs saving me over $500 a month.”

She tests her blood glucose levels ten times a day on average, uses ketone strips monthly and lancets weekly. Araica is concerned about her future ability to afford the costs of managing her diabetes if she moves out of the Yukon. Her workplace insurance recently stopped covering the cost of pump supplies. Fortunately, Yukon Health covers the cost of pump supplies, so Araica is not out-of-pocket.

Araica’s access to medical support is also a cost pressure. She sees a family physician regularly in Whitehorse, as well as a dietitian and diabetes educator. However, she needs to travel to Vancouver to see her endocrinologist every six months and an ophthalmologist yearly, the cost of which is also covered by Yukon Health.

Karen Heynen, 45
Whitehorse, Yukon
Karen is successfully managing her diabetes through an active lifestyle and with a workplace drug plan covering most of her diabetes medications and supplies, she has no financial barriers to managing her diabetes.

When diagnosed with type 2 diabetes in 2001, Karen had difficulties establishing her diabetes management plan, but now she has good control of her diabetes. She tests her blood glucose levels three or four times daily and also takes cholesterol medication prescribed by her doctor.

Karen is vigilant. “There are certain ground rules you follow – it’s not rocket science and I don’t have any big issues with diabetes. Once I was out in the bush and had nothing to eat. Fortunately I had my dextrose tablets with me but realized right then that I have to be more conscious of my diabetes, since there isn’t a place where I can buy a sandwich every time my blood sugar gets low.

Karen has a family doctor, but no endocrinologist. She has worked with a diabetes educator. “Being a nurse, it’s been easier for me to get support and information about diabetes than ordinary Yukoners.”
Footnotes


2 Diabetes Care, March 2003.

3 The online survey was conducted between May 27 and July 3, 2005 by SES Research Inc. The sample consisted of 1,089 members of the Canadian Diabetes Association and 908 Diabète Quebec members who responded to a request to participate. The margin of accuracy for the two surveys is 3 percent, 19 times out of 20 and 3.3 percent, 19 times out of 20 respectively.

4 A Ten Year Plan to Strengthen Health Care (16 September 2004).

5 S. Harris et al., “Diabetes in Canada Evaluation (DICE)” in Diabetes Research and Clinical Practice (October 2005).

6 Shields & Tjepkema, Nutrition: Findings from the Canadian Community Health Survey; Statistics Canada (July 2005) – 23 percent of Canadians over 18 are obese, and an additional 36 percent are overweight. Shields, Overweight Canadian Children & Adolescents; Statistics Canada (July 2005) – 29 percent of children between 12 and 17 years are overweight or obese.